

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155482	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2011
---	---	---	---

NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

K 000 INITIAL COMMENTS

A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

Survey Date: 02/10/11

Facility Number: 000529
Provider Number: 155482
AIM Number: 100267140

Surveyor: Amy Kelley, Life Safety Code Specialist

At this Life Safety Code survey, Kendallville Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 60 and had a census of 29 at the time of this survey.

Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/14/11.

The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:

K 000

This plan of correction is to serve as Kendallville Manor's credible allegation of compliance.

Submission of this plan of correction does not constitute an admission by Kendallville Manor or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of life safety and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.

RECEIVED

MAR - 2 2011

LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Vickie Bortna</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2/24/11</i>
---	-------------------------------	-----------------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

APPROVED

OMB CMS-2367 (02-99) Previous Versions Obsolete

Event ID: Z3TV21

Facility ID: 000529

If continuation sheet Page 1 of 4

3/8/11 AA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155482	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 5 exit discharge paths was readily accessible at all times. This deficient practice could affect all residents evacuated through the 100 hall exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/10/11 at 1:45 p.m., the 100 north hall exit discharge path was covered in up to four inches of drifted snow. Measurements were provided by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>	K 038	<p>K038 EXITS READILY ACCESSIBLE</p> <p>It is the practice of Kendallville Manor managers to conduct routine rounds that include each exit door during daily rounds.</p> <p>I. The exit discharge path was cleared of all drifted snow by the Maintenance Director at the end of the Life Safety tour and exit.</p> <p>II. Managerial rounds will continue in the facility daily. Managerial staff has been assigned, in addition to the Maintenance Director, to check each exit discharge path daily. The managerial staff is responsible to assure these pathways are clear of any blockage, including drifted snow.</p> <p>III. The facility policy regarding exit access has been reviewed with staff to assure that exits are readily accessible at all times in accordance with Life safety Code standards.</p> <p>IV. The Administrator or her designee is conducting quality improvement audits of each of the five (5) exits to assure compliance. Results of audits are reported to the facility's QA and Safety Committee which is held monthly for additional recommendations as necessary.</p> <p>COMPLETION DATE: 03/12/2011</p>	
K 046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide exterior emergency light for 5 of 5 exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for</p>	K 046		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155482	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 046	Continued From page 2 the exit access and exit discharge. This deficient practice could affect all occupants. Findings include: Based on observations with the Maintenance Director on 02/10/11 from 12:15 p.m. to 2:00 p.m., exterior light fixtures were observed at all exits and there were no exterior emergency battery operated lights provided. Based on an interview with the Maintenance Director at the time of observation, he could not confirm the light fixtures were on the emergency generator.	K 046	K046 EMERGENCY LIGHTING It is the practice of Kendallville Manor to inspect emergency lighting to assure operational duration of at least ninety (90) minutes. I. At dusk, the day of the survey, the exterior light fixtures were tested on the emergency generator by the Maintenance Director and found to be operational at all five (5) exits. II. An Outside Emergency Light Test Log has been implemented by the Maintenance Director to audit operational emergency lights during the use of the generator. These tests will take place on a monthly rotation. III. The facility policy regarding emergency lighting of at least ninety (90) minute duration has been reviewed by staff. Outside lighting is checked at dusk by the evening shift staff to assure lighting is operational. IV. The Maintenance Director or designee is conducting quality improvement audits of each of the five (5) exits to assure compliance. Results of audits are reported to the facility's QA and Safety Committee, overseen by the Administrator, which is held monthly for additional recommendations as necessary. COMPLETION DATE: 03/12/2011		
K 144 SS=F	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting system. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10	K 144			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155482	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 144	<p>Continued From page 3</p> <p>seconds after loss of normal power. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator log titled "Generator Load Testing Log Sheet" with the Maintenance Director on 02/10/11 at 12:15 p.m., the test switch for the emergency generator is no longer functional therefore power must be transferred manually. Based on interview at the time of record review, the Maintenance Director could not confirm if power from the main source to the emergency generator would take less than ten seconds. Based on a telephone conversation with the generator repair company at 2:00 p.m., if power from the main source fails then power would automatically transfer to the emergency generator.</p> <p>3.1-19(b)</p>	K 144	<p>K144</p> <p>EMERGENCY GENERATOR</p> <p>It is the practice of Kendallville Manor to inspect the generator weekly and exercised under load for thirty (30) minutes per month.</p> <p>I. The generator was manually tested and exercised under load for thirty (30) minutes without fail.</p> <p>II. Per conversation with the generator service company, the day of the survey, in the event of a power outage the generator will automatically transfer power to the facility. Current testing performed does require a manual transfer, and exercises more components of the transfer process.</p> <p>III. The facility has on order a replacement generator and transfer switch through Safe-Care. This is scheduled for installation on or before March 12, 2011.</p> <p>IV. The Maintenance Director or designee is conducting quality improvement audits of the generator inspection weekly and monthly per life Safety Guidelines. Results of all audits are reported to the facility's QA Committee, overseen by the Administrator, monthly for additional recommendations as necessary.</p> <p>COMPLETION DATE: 03/12/2011</p>		